

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16561

State File No. _____
Registrar's No. **4589**

FILED JUN 10 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY OR TOWN St Louis		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION MO PACIFIC HOSP.		e. STREET ADDRESS (If rural, give location) 4161 A. SHENANDOAH	
3. NAME OF DECEASED (Type or Print) a. (First) RAX b. (Middle) JOHN c. (Last) DAILEY		4. DATE OF DEATH (Month) (Day) (Year) MAY 23, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH JAN. 22, 1893
9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Yard Master	
10b. KIND OF BUSINESS OR INDUSTRY IRRA Railroad		11. BIRTHPLACE (City and State or Foreign Country) Glastonbury Conn	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Dailey	
13b. MOTHER'S MAIDEN NAME Josephine Avery		14. NAME OF HUSBAND OR WIFE Mary Boening Dailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 702 12 6403	
17. INFORMANT'S SIGNATURE OR NAME Mary B. Dailey		ADDRESS 4161a Shenandoah	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) metastases ANTECEDENT CAUSES Ca of stomach DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 151X			
22. I hereby certify that I attended the deceased from May 4, 1955 to May 23, 1955 , that I last saw the deceased alive on MAY 23, 1955 , and that death occurred at 12:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature]		23b. ADDRESS M.D.	
23c. DATE SIGNED 5-24			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 26 55	
24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St Louis Mo	
DATE REC'D BY LOCAL REG. MAY 25 1955		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE E.J. Schnur		ADDRESS 3125 Lafayette	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Thomas R. Fenwick*.....

Licensed Embalmer No. *379*.....

P. O. Address *31250 Lafa*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.